Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PAIN AND RECOVERY CLINIC NORTH
6660 AIRLINE DRIVE
HOUSTON TX 77076

Respondent Name

AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-1528-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility obtained pre-authorization on these services. In addition, the insurance carrier did NOT respond to the RFR. Our facility obtained pre-authorization for these services. In addition, the insurance carrier ONLY responded to DOS 2/8/10 & 2/9/10."

Amount in Dispute: $9,600.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Pending final review payment w/in 24-48 hours for DOS 2/1/10-2/9/10…Paid $600.00 [DOS February 15, -26, 2010]…Paid 12/15/11 [DOS February 24, 2010]…Pending final review payment w/in 24-48 hours for 3/1/2010."

Response Submitted by: Gallagher Basset Services, 16414 San Pedro Ave Suite 950, San Antonio, TX 78232

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 1, 2010	97799-CP	$600.00	$600.00
February 2, 2010		$600.00	$600.00
February 3, 2010		$600.00	$500.00
February 4, 2010		$600.00	$550.00
February 5, 2010		$600.00	$600.00
TOTAL		$3,600.00	$2,850.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.600 sets out the fee guidelines for the reimbursement of workers' compensation non-emergency health care requiring preauthorization provided on or after May 2, 2006.
3. 28 Texas Administrative Code §134.204 sets out medical Fee Guidelines for workers' compensation specific services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 23, 2010
   - 216 – Based on the findings of the review organization.

Issues

1. Has the respondent paid the requestor additional reimbursement?
2. Is the respondent's denial reason "216" supported?
3. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
4. Is the requestor entitled to reimbursement?

Findings

1. The Division contacted the requestor on April 3, 2012 requesting dispute payment status. The requestor indicated that the only disputed dates of service that remain unpaid are February 1, 2010, February 2, 2010, February 3, 2010 (carrier paid $100.00), February 4, 2010 (carrier paid $50.00) and February 5, 2010.
2. The respondent denied the disputed services based on "216 – Based on the findings of the review organization." Per Texas Labor Code, Section §413.011(b) "the insurance carrier is not liable for those specified treatment and services unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or order by the commission." 28 Texas Administrative Code, Section §134.600(c)(1)(B) states, "the carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury…only when the following situations occur…preauthorization of any health care listed in subsection (p) of this section was approved prior to providing the health care."
3. 28 Texas Administrative Code, Section §134.600(p) (10) requires preauthorization of "chronic pain management/interdisciplinary pain rehabilitation." Review of the submitted preauthorization letters sufficiently supports that the requestor obtained preauthorization approval under number 8382027 on January 26, 2010 for a Chronic Pain Management program x 10 sessions and preauthorization approval under number 8391141 on February 11, 2010 for a Chronic Pain Management program x 10 sessions which includes the disputed services rendered February 1, 2010 through March 1, 2010.
4. Per 28 Texas Administrative Code, Section §134.204(h)(5)(B), a chronic pain management program shall be reimbursed $125.00 per hour for a CARF accredited program. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes. A CARF accredited program is indicated by using the modifier –CA. The requestor did not provide the CARF accredited modifier; therefore, the monetary value of the program will be 80% of the CARF accredited value. CPT code 97799-CP will be reimbursed at $100.00 per hour as follows:

   DOS February 1, 2010: $100.00 x 6 hours = $600.00

   DOS February 2, 2010: $100.00 x 6 hours = $600.00

   DOS February 3, 2010: $100.00 x 6 hours = $500.00 (Carrier paid $100.00 on February 16, 2011)

   DOS February 4, 2010: $100.00 x 6 hours = $550.00 (Carrier paid $50.00 on February 16, 2011)

   DOS February 5, 2010: $100.00 x 6 hours = $600.00

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ 2,850.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,850.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 11, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.